Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HARLINGEN BONE & JOINT CLINIC PA
SUITE A
1801 NORTH ED CAREY DRIVE
HARLINGEN TX 78550

Respondent Name
Texas Mutual Insurance Company

Carrier's Austin Representative
Box Number 54

MFDR Tracking Number
M4-10-2552-01

MFDR Date Received
January 15, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are writing you this letter because we have been denied twice—initially and upon reconsideration to the insurance carrier—the consult—99244 for date of service, 09/09/2009. The reason for both denials was that the documentation did not support a level 4 consult. We maintain that this is indeed deserving of a level 4 consult and that the audit of this claim was not done correctly. Please examine the enclosed documentation carefully and reconsider this claim for proper payment. ."

Amount in Dispute: $379.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided evaluation and management services on 9/9/09 then billed Texas Mutual CPT code 99244 for this. Upon review of the billing and documentation of the service Texas Mutual concluded the documentation did not meet the coding requirements for 99244 as follows. The HPI should be Extended but is Brief instead."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 9, 2009	99244	$379.98	$262.32

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 150 – Payer deems the information submitted does not support this level of service
   - 16 – Claim/service lacks information which is needed for adjudication.
   - 45 – Charge exceeds fee schedule/maximum allowable for contracted/legislated fee arrangement
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information
   - 793 – Reduction due to PPO contract. PPO contract was applied by Focus/Aetna Comp Access LLC
   - 890 – This level of service is being disputed as it does not meet the components as defined in the "CPT Book."

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Did the requestor submit documentation to support the level of service billed?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced disputed services with reason codes "45 – Charge exceeds fee schedule/maximum allowable for contracted/legislated fee arrangement" and "793 – Reduction due to PPO contract. PPO contract was applied by Focus/Aetna Comp Access LLC. Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on October 6, 2010 the Division requested the respondent to provide a copy of the referenced contract as well as a documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment pursuant to the applicable Division rules and fee guidelines.
2. Per 28 Texas Administrative Code §134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor seeks reimbursement for CPT code 99244 rendered on September 9, 2009. The AMA CPT book's definition of CPT code 99244 is "Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family."

   Review of the documentation submitted by the requestor documents the level of service billed as a result, the requestor is entitled to reimbursement pursuant to Per 28 Texas Administrative Code §134.203 (c).
3. Per 28 Texas Administrative Code §134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   The Medicare Physician Fee Schedule (MPFS) reimbursement amount for CPT 99244 is $176.25 with the application of the annual percentage adjustment for 2010, the MAR reimbursement is $262.32, therefore this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $262.32.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $262.32 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		October 17, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.